Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

APPLICATION FOR FAMILY PLANNING OR MATERNITY MEDICAL BENEFITS

This application is only for pregnant women over the age of 19 requesting medical benefits.

If you are pregnant and age 19 or over, fill out and mail or fax this application to your loc Department of Social and Health Services (DSHS) Community Service Office (CSO). If you have questions, call Healthy Mothers, Healthy Babies:

1-800-322-2588
TDD/TTY Only 1-800-833-6385

If you are:

- Pregnant and **under the age of 19**, call 1-800-562-3022 (TDD/TTY only 1-800-848-5429).

- Pregnant and an adult who would like to apply for Basic Health maternity benefits, call 1-800-660-9840.

- An adult who is not pregnant and would like to apply for food stamps or a cash grant, call your local CSO. You need a yellow Application for Benefits, DSHS 14-001(X). To find your CSO's telephone number, look in the blue (government) pages of your phone book under Washington State, Community Services Office (CSO).

Health Care for Pregnant Women. . .
at no cost to you.

Here's How to Apply!

Here is a checklist to help you fill out your application:

- ◯ Family income: Any income your household receives. Use information on:
  - Recent pay stubs showing husband/wife or all family's income;
  - Letter from employer stating GROSS wages (before taxes are taken out);
  - Court Custody Agreement if someone is getting child support;
  - Self-employment records for the last 30 days; or
  - Award letters for benefits (some examples: Veterans Administration, Labor & Industries, Unemployment, Social Security).

- ◯ **Include the Social Security number for the pregnant woman**

AND

- ◯ **Verification of pregnancy from a licensed medical provider such as a doctor, nurse, or lab technician.**

Please mail or fax your completed application with proof of income and pregnancy verification to the local Community Service Office (CSO).

Current Basic Health members who become pregnant must call 1-800-660-9840 to obtain a Basic Health Maternity Benefits application.

Washington State Department of Social & Health Services

APPLICATION FOR MATERNITY MEDICAL BENEFITS

Please read the following before completing the application.

This application is a statement of facts about the pregnant woman who needs medical care. You will need to answer all questions before we will know if we can help you. Please print.

Organization or provider assisting client with application: _____

1. First Name	Middle Initial	Last Name

2. Address Where You Live	Street	City	State	Zip Code

3. Mailing Address (If different)	Street	City	State	Zip Code

4. Telephone Numbers	5.	Yes	No
Home	Do you have trouble speaking, reading or writing English?	☐	☐
Work	Do you need an interpreter? (If yes, we will communicate through an interpreter.)	☐	☐
Message	What language do you speak? _____		

6. The pregnant woman's delivery due date _____

7. Does the pregnant woman have a medical condition which needs medical attention right away?	Yes	No
	☐	☐

General Information

8. List yourself and everyone living at your address. Use legal names. **Do Not Use Nicknames.** If you do not know a Social Security Number, leave it blank.

NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO YOU	BIRTH DATE (MO/DA/YR)	APPLYING FOR BENEFITS? YES	APPLYING FOR BENEFITS? NO	*U. S. CITIZEN YES	*U. S. CITIZEN NO	SOCIAL SECURITY NUMBER	SEX M or F
A.	SELF							
B. List Others in Household								
C.								
D.								
E.								
F.								
G.								
H.								

Expenses

9. Do you pay someone to take care of your child(ren) or take care of a dependent adult while you work?	Yes ☐	No ☐	If yes, how much per month?
10. Do you pay child support for a child who is not in your home?	Yes ☐	No ☐	If yes, how much per month?

*If you are not a U.S. citizen, complete Page 3 - Immigration Status

DSHS 14-429(X) (06/1999)

Enter GROSS pay, not take home pay. Enter zero ("0") if you or your spouse are not employed.

Income

Your Income From Employment	Spouse's Income From Employment (if you are married)
11. Employer Name and Phone Number	13. Employer Name and Phone Number
12. Amount you earn each pay period before taxes: _____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Hours worked each week _____	14. Amount you earn each pay period before taxes: _____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Hours worked each week _____

Other Income	Amount	How Often Do You Get This Income?	Which Family Member Gets This Income?
15. Child Support or Alimony			
16. Social Security payment			
17. Unemployment benefits			
18. Interest from bank account			
19. Veterans Benefits			
20. Labor and Industries			
21. Military Allotments			
22. Other (Please explain)			

Medical Information

23. Do you already have health insurance? Yes ☐ No ☐

If you checked "yes", list the name of your insurance company or employer, the policy number and the policy holder's name and social security number. Even if you already have health insurance, you can still qualify for medical benefits.

Insurance Company or Employer	Policy Number	Policy Holder's Name	Policy Holder's SSN

24. Did any of you receive medical services in the past 3 months including Maternity Support Services and/or Maternity Case Management? Yes ☐ No ☐

Voluntary Information

We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for benefits.

☐ Caucasian ☐ Hispanic ☐ Black ☐ Native American/Alaskan Native ☐ Vietnamese/Laotian/Cambodian
☐ Other Asian or Pacific Islander ☐ Other _____

Read Carefully Before Signing

I UNDERSTAND THAT:

- I must report immediately to the Department of Social and Health Services (DSHS), in writing or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by DSHS or other state or federal agencies.
- I must provide proof I am eligible for help. DSHS may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.
- DSHS may share your child's immunization history with the Department of Health's Child Profile Immunization Tracking System for purposes directly connected to the administration of medical programs.
- **I understand this application is for medical benefits for the pregnant woman only. If my family needs financial assistance or food stamps, we must apply through a DSHS Community Services Office.**

Immigration Status

Please complete this section for any person applying for medical benefits who is not a United States citizen except for foreign students and tourists. If you have legal immigration status, attach copies of both sides of the document. You do not have to provide proof of immigration status for the family members who are not applying for benefits.

Name of person applying for medical care		Are you a United States citizen?		If not a United States Citizen		
				Were you given a document showing your status?		If yes, list date you arrived in the United States
First	Last	YES	NO	YES	NO	
First	Last					
First	Last					
First	Last					
First	Last					
First	Last					

Declaration and Signature(s)

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature of Applicant	Date

Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, age, sex or disability.